ACCIDENT REPORT NAME _____ # _____ DATE _____

Date of accident _____ Hour _____ AM/PM Location _____

How did accident occur? ___Auto collision ___On the job injury

___Other _____

Please describe the circumstances. _____

_____

_____

Your occupation _____ employed by _____

employer's address _____

Did you report the injury to your employer? ___yes ___no

Did they recommend care at our office? ___yes ___no

If auto accident, were you ___driver ___passenger ___pedestrian

If auto collision, were you struck from ___behind ___L side ___R side

___front ___auto was parked

Did your car strike the other(s) involved? ___yes ___no

or did the other car strike yours? ___yes ___no driver's name _____

As a result of the accident, were traffic citations issued to you? ___yes ___no

to the driver of the other car ___yes ___no

to the driver of your car ___yes ___no

List the extent of your injuries as you know them _____

_____

_____

Did you require post-accident hospitalization? ___yes ___no

Other doctors you have seen: Dr. _____ Date _____ Treatment _____

Dr. _____ Date _____ Treatment _____

Check symptoms you have noticed SINCE THE ACCIDENT:

COMPLAINTS:

SHORTNESS OF BREATH
EXCESSIVE PERSPERATION
MID BACK (PAIN; STIFFNESS)
LOW BACK (PAIN; STIFFNESS)
SWELLING (WHERE) _____
FEET COLD; HANDS COLD
RESTRICTION OF NECK MOTION
UPPERBACK PAIN AND STIFFNESS
BUZZING AND/ OR RINGING IN EARS
EYES SENSITIVE TO LIGHT, LOSS OF FOCUS
HEAD AND SHOULDERS FEEL TIRED; HEAVY
PINS AND NEEDLES IN (ARMS; LEGS)
NUMBNESS IN (FINGERS; ARMS; LEGS)
DIFFICULTY IN RIDING IN A CAR
HEADACHE
NECK PAIN
NECK STIFFNESS
INSOMNIA
TENSION
IRRITABILITY

☐ LOSS OF TASTE
☐ LOSS OF SMELL
☐ LOSS OF MEMORY
☐ DIARRHEA
☐ NEURITIS
☐ ANXIETY
☐ FAINTING
☐ CHEST PAIN
☐ DIZZINESS
☐ CONSTIPATION
☐ DEPRESSION
☐ EYESTRAIN
☐ NAUSEA, VOMITING
☐ FACE FLUSHED
☐ PALPITATION
☐ TREMORS
☐ SINUS TROUBLE
☐ MENTAL DULLNESS
☐ EXTREME NERVOUSNESS
☐ EXTREME FATIGUE
☐ PAIN BEHIND EYES

☐ DOUBLE VISION
☐ DIGESTIVE DISORDERS
☐ EQUILLIBRIUM PROBLEMS
☐ HEAD SEEMS TOO HEAVY
☐ DIFFICULTY IN EXCESSIVE
☐ STANDING ☐ WALKING
☐ RIDING ☐ BENDING
☐ NECK (PAIN; STIFFNESS) UPON ARISING
☐ LOW BACK (PAIN; STIFFNESS) UPON ARISING
☐ PAIN RADIATING INTO ☐ ARM; ☐ LEG
☐ RIGHT; ☐ LEFT; ☐ BOTH
☐ DIFFICULTY IN LIFTING
☐ LT. ☐ MOD.
☐ HVY. ☐ REPET.
PAIN RADIATING INTO
☐ NECK
☐ BASE OF SKULL
☐ SHOULDER
☐ ARMS
☐ HIPS
☐ LEGS

SYMPTOMS OTHER THAN ABOVE _____

EMPLOYMENT

Have you lost any days of work because of the accident?

From_____to_____

Have your work duties been modified at all since the accident?

Describe_____

INSURANCE

If auto accident, whom was at fault /__/ Other Driver /__/ Yourself

Please give name and location of:

your auto insurance company_____
AND carrier (local agency) _____

other driver's auto insurance company_____
AND carrier (local agency)_____

Personal injury insurance carrier_____
AND address_____

Have you been contacted by an insurance adjustor or company representative regarding this claim? ___yes ___no

Do you have an attorney who has advised you in this case? ___yes ___no

name_____

address_____

phone_____

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

signature_____

Auto Accident

Date of accident: _____

Your role was (circle one): Back seat passenger, Front seat passenger, Driver of motorcycle, Other, Driver with (left/right) hand on the wheel, Driver with both hands on the wheel

What was the vehicle's status? _____

What area of the vehicle was impacted? _____

It was (circle one): Dawn, Dusk, Full Daylight, Night

Road conditions were (circle one): Damp, Dry, Icy, Nasty, Snow covered, Wet

Rate the visibility (circle one): Excellent, Fair, Good, Poor

What type was the other vehicle involved? _____

What would you guess was the speed of the other vehicle? (end in 0 or 5) _____

In what position was your headrest? _____

Were you admitted to a hospital?_____If yes, was it at the time of the accident

or at a later time? _____

How did you get to the hospital? _____

What was your attending doctor's name?_____

How many days were you in the hospital?_____

Choose one –
_____I was able to brace for impact with my (hands, feet, or knees).
_____I was aware the accident was coming, but unable to brace.
_____I was not aware the accident was impending.

Circle the problem for the accident:

Brightness, Darkness, Fog, Rain, Snow, Traffic

Where are your injuries? _____

_____